Oral Sodium Phosphate Litigation
Plaintiff's Preliminary Fact Sheet

PLAINTIFF CONTACT INFORMATION

Last Name:_____ First Name:_____
Address:_____
Telephone:_____
Spouse's Name:_____

PLAINTIFF'S ATTORNEY CONTACT INFORMATION

Name:_____
Law Firm:_____
Address:_____
Telephone:_____ Email:_____

PLAINTIFF'S PERSONAL AND HEALTH INFORMATION

Date of Birth (mm/dd/yyyy): _____
Gender: ○ Male ○ Female
Are you African-American[1]?: ○ Yes ○ No

Did you use a Fleet Phospho-Soda product? ○ Yes ○ No
If your answer is "Yes," which Fleet Product did you use? (check all that apply)

- ❑ Fleet Phospho-Soda (1.5 ounce/45 mL)
- ❑ Fleet Phospho-Soda (3.0 ounce/90 mL)
- ❑ Fleet Accu-Prep
- ❑ Fleet Phospho-Soda EZ-Prep
- ❑ Other: _____

On what date(s) did you use the Fleet Product? (mm/dd/yyyy): _____ _____
_____ _____ _____ _____ _____

Did you use the Fleet Product in connection with a medical procedure? ○ Yes ○ No
If your answer is "Yes," state:

1. What medical procedure? _____
2. What was the date of the medical procedure? (mm/dd/yyyy):_____
3. Name and address of the doctor who performed the medical procedure?_____
   _____
   _____

[1] Plaintiff's race is requested in order to calculate estimated normal kidney function, which depends on race, gender, and age, among other factors. Kidney function is measured by glomerular filtration rate ("GFR"), using the Modification of Diet in Renal Disease ("MDRD") Study equation; this equation uses different factors depending on the patient's race. *See* www.nkdep.nih.gov/professionals/gfr_calculators/orig_con.htm .

DETAILS OF FLEET PRODUCT USE

Please answer the following questions regarding the manner in which you used the Fleet Product.

A. Number of doses: _____
B. Amount of Fleet Product in each dose:_____
(Please state in ounces (oz), milligrams (mL), or some other estimated volume, such as teaspoons or tablespoons).
C. Amount of time (in hours) between doses: _____
D. Other laxative products used at the same time: _____

List any medications you were taking during the period starting two weeks before you used the Fleet Product through the time you were diagnosed with the injuries you are claiming:_____
_____
_____
_____
_____
_____
_____
_____

DETAILS OF KIDNEY FUNCTION

Do you know what your serum creatinine level was the last time it was measured before using a Fleet Product? ○ Yes ○ No
If you answered "Yes," state the measurement: _____
The approximate date of the measurement (mm/dd/yyyy):_____

Do you know what your serum creatinine level was the first time it was measured after using a Fleet Product?
○ Yes ○ No
If you answered "Yes," state the measurement: _____
The approximate date of the measurement (mm/dd/yyyy): _____

What is your most recent serum creatinine level? _____
What is your most recent eGFR (estimated glomerular filtration rate)? _____

Have you ever been diagnosed with kidney disease? ○ Yes ○ No
If you answered "Yes," state the date you were first diagnosed (mm/dd/yyyy): _____
Name and address of the doctor making that diagnosis: _____
_____
_____

Have you had a kidney biopsy? ○ Yes ○ No
If you answered "Yes," state the date of the biopsy (mm/dd/yyyy): _____

Have you ever required dialysis? ○ Yes ○ No
If you answered "Yes," state:

1. the type of dialysis you had:_____
2. the period you underwent dialysis (mm/dd/yyyy):_____to _____
3. the frequency of the treatments (e.g., daily, 2x/week; 3x/week): _____

Have you been placed on a kidney transplant list? ○ Yes ○ No
If you answered "Yes," state the date you were first put on such list (mm/dd/yyyy): _____

Have you had a kidney transplant? ○ Yes ○ No
If you answered "Yes," state the date of the transplant (mm/dd/yyyy): _____

Have you suffered any injury other than kidney disease that a doctor has related to your use of a Fleet Product? ○ Yes ○ No
If you answered "Yes," state:
1. the type of injury:_____
2. the date you were diagnosed with that injury (mm/dd/yyyy):_____
3. the name and address of the doctor who made that diagnosis: _____
   _____
   _____

RECORDS

Please provide copies of the instructions you received for taking the Fleet Product, and all medical records in your possession, including records related to:

a. your use of the Fleet Product, including but not limited to pre-procedure records, procedure records, or post-procedure records showing your use of the Fleet Product;
b. lab reports (blood work) which indicate your creatinine levels from before you used the Fleet Product;
c. lab reports (blood work) which indicate your creatinine levels from after you use the Fleet Product;
d. report of any kidney biopsy;
e. the diagnosis of acute or chronic kidney disease;
f. any treatment you received for acute or chronic kidney disease; and
g. diagnosis and any treatment you received for any injury other than kidney disease.

ATTACH A LIST OF THE NAMES AND ADDRESSES OF ALL HEALTH CARE PROVIDERS WITH WHOM THE CLAIMANT HAS TREATED FOR RENAL DISEASE, INCLUDING ALL PRIMARY CARE PHYSICIANS.

SIGNATURES

The undersigned certifies that he or she believes the above information to be true and correct based on reasonable inquiry.

_____ _____
Claimant or Claimant's Attorney Date

ALSO: please sign the attached medical records authorization.